PRINTED: 01/06/2011 FORM APPROVED

Bureau of Health Care Quality and Compliance

AND PLAN OF CORRECTION IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		NVS3643AGC	643AGC		<u> </u>		C 12/07/2010	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
HACIENDA HILL MANOR				RREY STREET GAS, NV 89119				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
Y 000	Initial Comments			Y 000				
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted on your facility 11/18/10 through 12/7/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for eight Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was six. Five employee files were reviewed.							
	resident neglect was interview with facility	6960 - The allegation of not substantiated throu employees and a police as Police Department.	gh					
	•	960 - The allegation of s substantiated. See T						
Y 106 SS=E	449.200(2)(a) Person	nnel File - 1st aid & CPF	₹	Y 106				
	information required p	st include, in addition to pursuant to subsection g that the caregiver is perform first aid and						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Bureau of Health Care Quality and Compliance

NAME OF PROVIDER OR SUPPLIER HACIENDA HILL MANOR SUMMARY STATEMENT OF DEFICIENCIES S44 SURREY STREET LAS VEGAS, NV 89119	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER HACIENDA HILL MANOR STREET ADDRESS, CITY, STATE, ZIP CODE 5544 SURREY STREET LAS VEGAS, NV 89119 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Y 106 Continued From page 1 This Regulation is not met as evidenced by: Based on interview and record review on 11/18/10, the facility failed to ensure 1 of 4 caregivers had evidence of pulmonary resuscitation (CPR) and first aid training (Employee #3).										
HACIENDA HILL MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Y 106 Continued From page 1 This Regulation is not met as evidenced by: Based on interview and record review on 11/18/10, the facility failed to ensure 1 of 4 caregivers had evidence of pulmonary resuscitation (CPR) and first aid training (Employee #3).		20,4555 05 01,551,455	NVS3643AGC	CTDEET ADDR			12	/07/2010		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Y 106 Continued From page 1 Y 106 This Regulation is not met as evidenced by: Based on interview and record review on 11/18/10, the facility failed to ensure 1 of 4 caregivers had evidence of pulmonary resuscitation (CPR) and first aid training (Employee #3).				5544 SURREY STREET						
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		Based on interview a 11/18/10, the facility caregivers had evide resuscitation (CPR) (Employee #3).	and record review on failed to ensure 1 of 4 ence of pulmonary and first aid training							